

MDR Tracking Number: M5-05-0095-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-2-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 8-20-03 through 8-27-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, therapeutic exercises, neuromuscular reeducation, electrical stimulation, hot-cold packs and DME items from 9-9-03 through 5-5-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-17-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 99213 on dates of service 9-2-03, 9-9-03, 9-10-03, 9-16-03, 9-17-03, 9-19-03, 9-22-03, 9-23-03, 9-24-03, 9-29-03, 9-30-03, 10-01-03, 10-06-03, 10-07-03, 10-08-03, 10-14-03, 10-16-03, 10-20-03, 10-21-03, 10-24-03, 10-27-03, 10-28-03, 10-29-03, 11-03-03, 11-04-03, 11-06-03, 11-10-03, 11-11-03, 11-12-03, 11-18-03, 11-19-03, 11-20-03, 11-24-03, 11-26-03, 12-01-03, 12-02-03 and 12-03-03 was denied by the Carrier with an L – “Not TD approved treatment.” The requestor submitted the TWCC 53 report showing that Angela Upchurch was the Treating Doctor. **Recommend reimbursement of \$2,449.03 (\$66.19 X 37 DOS).**

The carrier denied CPT Code 99080-73 on 10-07-03, 11-06-03, 12-09-03, 1-06-04 and 2-10-04 with a U for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of \$75.00 (\$15.00 X 5 DOS).**

CPT code 97750 on dates of service 9-15-03 (5 units) and 10-31-03 (4 units) was denied by the Carrier with an L – “Not TD approved treatment.” The requestor submitted the TWCC 53 report showing that Angela Upchurch was the Treating Doctor. **Recommend reimbursement of \$332.46 (\$36.94 X 9).**

CPT code 97750 on date of service 12-12-03 (4 units) and 12-22-03 (4 units) was denied by the Carrier with an F- ‘Fee Guideline MAR reduction.’ In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Recommend reimbursement of \$295.52 (\$66.19 X 8).**

Regarding CPT code 97750 on dates of service 3-17-04 (4 units) and 6-29-04 (4 units): Neither the carrier nor the requestor provided EOB’s. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s Per Rule 133.307(e)(3)(B). Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider’s usual and customary charge). **Recommend reimbursement of \$295.52 (\$36.94 x 8 units.)**

CPT code 99213 on date of service 10-15-03 was denied by the carrier with an E – Entitlement to Benefits. The carrier has provided no TWCC 21 supporting its position. **Recommend reimbursement of \$66.19.**

CPT code 97112 on date of service 10-15-03 was denied by the carrier with an E – Entitlement to Benefits. The carrier has provided no TWCC 21 supporting its position. **Recommend reimbursement of \$73.88.**

CPT code 97032 on date of service 10-15-03 was denied by the carrier with an E – Entitlement to Benefits. The carrier has provided no TWCC 21 supporting its position. **Recommend reimbursement of \$20.85.**

CPT code 97110 on dates of service 10-15-03, 12-22-03, 3-11-04, 3-24-03 and 3-31-04 was denied with an E – Entitlement to Benefits, an F – Fee Guideline MAR reduction or neither party provided EOB’s. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

Code 97010 billed on dates of service 10-16-03, 11-04-03, 11-10-03, 11-19-03 and 11-20-03 was denied as “G” – unbundling. Procedure code 97010 will be bundled into the payment for all other services including, but not limited to, office visits and physical therapy.” The Trailblazer Local Coverage Determination (LCD) states that code 97010 “is a bundled code and considered an Integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed.

Regarding HCPCS code E0745 on dates of service 10-20-03: Neither the carrier nor the requestor provided EOB’s. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$111.89 per the HCPCS DMEPOS list.**

CPT Code 97032 billed on dates of service 11-20-03 and 12-22-03 was denied as “F – invalid CPT Code. However, according to Ingenix Encoder Pro this is a valid CPT Code. **Reimbursement is recommended in the amount of \$41.70 (\$20.85 x 2 DOS).**

CPT Code 99213 billed on dates of service 12-22-03 was denied as “F – Fee Guideline MAR reduction. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$66.19.**

CPT Code 99455 RV5 billed on date of service 11-25-03 was denied by the carrier with a U for unnecessary medical treatment, however, according to Rule 134.202(e)(6)(B)(iii), this exam is not subject to IRO review. The requestor billed the above service in accordance with Rule 134.202 (e)(6)(D)(II). The requestor submitted relevant information to support delivery of service. **Reimbursement is recommended in the amount of \$50.00.**

Neither the carrier nor the requestor provided EOB’s for CPT code 99213 on dates of service 3-11-04 and 3-24-03. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$136.48 (\$68.24 x 2 DOS)**

Neither the carrier nor the requestor provided EOB’s for CPT code 97112 on date of service 3-11-04. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$74.10 (\$37.05 x 2 units).**

This Finding and Decision is hereby issued this 17th day of February , 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to

pay for the unpaid medical fees

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 9-2-03 through 6-29-04 as outlined above in this dispute.

This Order is hereby issued this 17th day of February , 2005.

Margaret Ojeda, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

Ph. 512/248-9020
IRO Certificate #4599

Fax 512/491-5145

NOTICE OF INDEPENDENT REVIEW DECISION

November 9, 2004

Re: IRO Case # M5-05-0095 amended 1/20/05, 2/8/05

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed in Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. DDE 10/18/03
4. RME 7/19/04
5. MRI report sacral area 7/19/04
6. M.D. chart notes
7. Report 7/6/04
8. MRI report lumbar spine 4/29/03
9. MRI report coccyx 6/11/04
10. CT scan report sacrum and coccyx 6/16/03
11. Surgical report 5/3/04
12. IME report 3/31/04
13. D.C. treatment notes
14. PPEs 9/15/03, 10/31/03, 12/12/03, 3/17/04, 6/29/04
15. D.C. rehabilitation exercise cards

History

The patient injured his low back and coccyx in ____ when he slipped and fell. He initially saw his treating chiropractor on 6/2/03. He has been treated with epidural steroid injections, medication, and physical therapy.

Requested Service(s)

Office visits, therapeutic exercises, neuromuscular reeducation, electric stim, hot/cold packs, DME items, 9/9/03 – 5/5/04

Decision

I agree with the carrier's decision to deny the requested services and items.

Rationale

The patient had an adequate trial of chiropractic treatment prior to the dates in dispute without relief of symptoms or improved function. A 7/19/04 report indicated that the patient still had a VAS of 7/10 and was in severe pain in all ranges of motion. The report stated that all previous treatment and injections had not provided relief of symptoms. This was after several months of treatment from his D.C.

A 10/18/03 DDE report indicated that the patient's pain ranged from 7-9/10. The report stated that examination revealed no positive orthopedic test, and only tenderness to palpation at S1. He had a normal gait and posture, and noted that the patient wanted to return to work in some capacity. It appears from the records provided for this review that the patient's condition actually deteriorated under the D.C.'s care. On 6/29/04, about one year after treatment started, the D.C. noted that the patient's pain was 8/10, and that it was stabbing and throbbing when the patient stood. He also walked with a forward lean.

The D.C.'s documentation that provided for this review lacked subjective complaints and objective findings to support the treatment in dispute. As of 8/20/03 the patient's condition had plateaued in a diminished state and further treatment failed to be beneficial. The patient's subjective pain levels and complaints remained unchanged despite continued treatment past 8/20/03. There was no progress toward functional, objective improvements. The D.C.'s documentation failed to show any progression of the rehabilitation program or a move toward self-directed care. Treatment was inappropriate and over utilized by 8/20/03.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Daniel Y. Chin, for GP